OMB No. 1115-0048

**U. S. Department of Justice**
Immigration and Naturalization Service

# Application for Waiver of Ground of Excludability

## Please read instructions carefully. Fee will not be refunded.

Please type or print plainly with a ball point pen.

### I. Filing the Application

The application and supporting documents should be taken or mailed to:

The American Consulate at which the applicant is applying for a visa, if the applicant is not in the United States; or

The office of the Immigration and Naturalization Service having jurisdiction over the applicant's place of residence, if the applicant is in the United States, and is applying for status as a permanent resident.

### II. Fee

No fee is required if this application is filed for an alien who:

Is afflicted with tuberculosis;

Is mentally retarded; or

Has a history of mental illness.

All other applications must be accompanied by a fee of one hundred seventy dollars ($170). (Only a single application and fee shall be required when the alien is applying simultaneously for a waiver under both section 212(h) and (i) of the Act. The fee cannot be refunded, regardless of the action taken on the application. **Do not mail cash.**

Payment must be made by a check or money order:

Drawn on a bank or other institution located in the United States;

Payable in United States currency; and

**Payable in the exact amount ($170).**

If the check is drawn on an account of a person other than the applicant, the name of the applicant must be entered on the face of the check.

Personal checks are accepted subject to collectibility. An uncollectible check will void the application and any documents issued pursuant to the application. A charge of $30.00 will be imposed if the check is not honored by the bank on which it is drawn.

Unless the applicant resides in the Virgin Islands or Guam, the check or money order must be made payable to the "Immigration and Naturalization Service".

If the applicant resides in the Virgin Islands, make the check or money order payable to the "Commissioner of Finance of the Virgin Islands".

If the applicant resides in Guam, make the check or money order payable to the "Treasurer, Guam".

### III. Applicants with Tuberculosis

An applicant with active tuberculosis or suspected tuberculosis must complete Statement A on page two of this form. The applicant and his or her sponsor is also responsible for having:

Statement B. completed by the physician or health facility which has agreed to provide treatment or observation, and Statement D, if required, completed by the appropriate local or state health officer.

This form should then be returned to the applicant for presentation to the consular office, or to the appropriate office of the Immigration and Naturalization Service.

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Submission of the application without the required, fully executed statements will result in the return of the application to the applicant without further action.

### IV. Applicants with Mental Conditions

An alien who is mentally retarded or who has a history of mental illness shall attach a statement that arrangements have been made for the submission of a medical report, as follows, to the office where this form is filed:

The medical report shall contain:

A complete medical history of the alien, including details of any hospitalization or institutional care or treatment for any physical or mental condition;

Findings as to the current physical condition of the alien, including reports of chest X-rays and a serologic test if the alien is 15 years of age or older, and other pertinent diagnostic tests; and

Findings as the current mental condition of the alien, with information as to prognosis and life expectancy and with a report of a psychiatric examination conducted by a psychiatrist who shall, in the case of mental retardation, also provide an evaluation of intelligence.

For an alien with a past history of mental illness, the medical report shall also contain available information on which the United States Public Health Service can base a finding as to whether the alien has been free of such mental illness for a period of time sufficient in the light of such history to demonstrate recovery.

The medical report will be referred to the United States Public Health Service for review and, if found acceptable, the alien will be required to submit such additional assurances as the United States Public Health Service may deem necessary in his or her particular case.

**Reporting Burden.** A person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Public reporting burden for this collection of information is estimated to average 30 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to: U. S. Department of Justice, Immigration and Naturalization Service, Room 5307, Washington, D. C. 20536; OMB No. 1115-0048. **DO NOT MAIL YOUR COMPLETED APPLICATION TO THIS OFFICE.**

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**U. S. Department of Justice**
Immigration and Naturalization Service

# Application for Waiver of Ground of Excludability

**DO NOT WRITE IN THIS BLOCK**

☐ 212 (a) (1 ) ☐ 212 (a) (10) Fee Stamp
☐ 212 (a) (3) ☐ 212 (a) (12)
☐ 212 (a) (6) ☐ 212 (a) (19)
☐ 212 (a) (9) ☐ 212 (a) (23)

**A. Information about applicant -**

1. Family Name (Surname In CAPS) (First) (Middle)

2. Address (Number and Street) (Apartment Number)

3. (Town or City) (State/Country) (Zip/Postal Code)

4. Date of Birth *(Month/ Day/ Year)* 5. I&N File Number A-

6. City of Birth 7. Country of Birth

8. Date of visa application 9. Visa applied for at:

10. Applicant was declared inadmissible to the United States for the following reasons: (List acts, convictions, or physical or mental conditions. If applicant has active or suspected tuberculosis, the reverse of this page must be fully completed.)

11. Applicant was previously in the United States, as follows:

| City & State | From (Date) | To (Date) | I&NS Status |
|---|---|---|---|
| | | | |
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| | | | |
| | | | |
| | | | |

12. Social Security Number

**B. Information about relative, through whom applicant claims eligibility for a waiver -**

1. Family Name (Surname in CAPS) (First) (Middle)

2. Address (Number and Street) (Apartment Number)

3. (Town or City) (State/Country) (Zip/Postal Code)

4. Relationship to applicant 5.I&NS Status

**C. Information about applicant's other relatives in the U.S.**
*(List only U.S. citizens and permanent residents)*

1. Family Name (Surname in CAPS) (First) (Middle)

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Signature (of applicant or petitioning relative)

Relationship to applicant Date

Signature (of person preparing application, if not the applicant or petitioning relative) I declare that this document was prepared by me at the request of the applicant, or petitioning relative, and is based on all information of which I have any knowledge.

Signature

Address Date

| Initial receipt | Resubmitted | Relocated | | Completed | | |
|---|---|---|---|---|---|---|
| | | Received | Sent | Approved | Denied | Retuned |
| | | | | | | |

Form I-601 (Rev. 10/13/98)N

## To be completed for applicants with active tuberculosis or suspected tuberculosis

**A. Statement by Applicant**

Upon admission to the United States I will:

1. Go directly to the physician or health facility named in Section B;
2. Present all X-rays used in the visa medical examination to substantiate diagnosis;
3. Submit to such examinations, treatment, isolation, and medical regimen as may be required; and
4. Remain under the prescribed treatment or observation whether on inpatient or outpatient basis, until discharged.

**Signature of *Applicant***

**Date**

**B. Statement by Physician or Health Facility**

(May be executed by a private physician, health de- partment, other public or private health facility, or military hospital.)

I agree to supply any treatment or observation necessary for the proper management of the alien's tuberculous condition.

I agree to submit Form CDC 75.18 "Report on Alien with Tuberculosis Waiver" to the health officer named in Section D:

1. Within 30 days of the alien's reporting for care, indicating presumptive diagnosis, test results, and plans for future care of the alien; or
2. 30 days after receiving Form CDC 75.18 if the alien has not reported.

Satisfactory financial arrangements have been made. (This statement does not relieve the alien from submitting evidence, as required by consul, to establish that the alien is not likely to become a public charge.)

I represent (enter an "X" in the appropriate box and give the complete name and address of the facility below.)

- ☐ 1. Local Health Department
- ☐ 2. Other Public or Private Facility
- ☐ 3. Private Practice
- ☐ 4. Military Hospital

Name of Facility (please type or print)

Address (Number & Street) (Apartment Number)

City, State & Zip Code

Signature of Physician Date

**C. Applicant's Sponsor in the U.S.**

Arrange for medical care of the applicant and have the physician complete Section B.

If medical care will be provided by a physician who checked box 2 or 3, in Section B., have Section D. completed by the local or State Health Officer who has jurisdiction in the area where the applicant plans to reside in the U.S.

If medical care will be provided by a physician who checked box 4., in Section B., forward this form directly to the military facility at the address provided in Section B.

Address where the alien plans to reside in the U.S.

Address (Number & Street) (Apartment Number)

City, State & ZIP Code

**D. Endorsement of Local or State Health Officer**

Endorsement signifies recognition of the physician or facility for the purpose of providing care for tuberculosis. lf the facility or physician who signed in Section B is not in your health jurisdiction and is not familiar to you, you may wish to contact the health officer responsible for the jurisdiction of the facility or physician prior to endorsing.

Endorsed by: Signature of Health Officer

Date

Enter below the name and address of the Local Health Department to which the "Notice of Arrival of Alien with Tuberculosis Waiver" should be sent when the alien arrives in the U. S.

Official Name of Department

Address (Number & Street) (Apartment Number)

City, State & ZIP Code

**Please read instructions with care.**

*If further assistance needed, contact the office of the Immigration and Naturalization Service with jurisdiction over the intended place of U.S. residence of the applicant.*

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Fee Stamp

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***Additional Information and Instructions***

Signature and Title of Requesting Officer

Address Date

**This office will maintain only a folder relating to the applicant pursuant the A.M.**